**STATE OF WASHINGTON**
**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**
Medicaid Purchasing Administration
*621 8th Avenue, S.E. • P.O. Box 45503*
*Olympia, Washington 98504-5503*

# Medicaid Provider Fraud and Abuse Complaint Referral Form

**Send to: DSHS HotTips**
**Or FAX to 360-586-0615**

**Please provide your contact information:**

| |
|---|
| Name: |
| Business Name: |
| Address: |
| City: State: ZIP: |
| E-mail address: |
| Telephone Number: |
| Other: |
| Preferred method of contact: |

**Please provide as much information about the provider as you can:**

| |
|---|
| Name: |
| Business Name: |
| Address: |
| City: State: ZIP: |
| Medicaid Provider Number, Business License Information, etc.: |

**Please provide as much specific information as you can:**

| |
|---|
| The alleged misbehavior (billing abuse, client safety, etc.): |
| When it occurred (date, single or multiple instances): |
| Where it occurred : |